

**SHORT CONFIDENTIAL PATIENT QUESTIONNAIRE**

Our concern is your hearing. So, to better help you, we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is **kept strictly confidential**, is not sold, and is made a part of your permanent hearing healthcare file. Thank you for placing your trust in us for all your hearing needs.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Current Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Primary E-Mail: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_

**Whom may we thank for referring you to us?**

Please indicate how you heard about our services by checking and completing one of the fields below:

- Physician (Last Name, First Name): \_\_\_\_\_
- Mailer     Newspaper Ad     Friend (Name): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

**Please answer 'yes' or 'no' to the following questions:**

Circle one

- Do you experience noises or ringing in your ears?..... Yes    No
- Do you hear better in one ear than the other?..... Yes    No
- Have any of your relatives had a hearing loss?..... Yes    No
- Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?..... Yes    No
- Do you sometimes feel people are mumbling or not speaking clearly?..... Yes    No
- Do you sometimes find yourself asking people to speak up or repeat themselves?..... Yes    No
- Do you have difficulty understanding soft or whispered speech?..... Yes    No
- Have you had a hearing test before?..... Yes    No
- Have you ever worn hearing aids?..... Yes    No
- Have you considered wearing hearing aids to improve your hearing?..... Yes    No

**Are you currently experiencing any of the following?:**

- \_\_\_\_ Physical deformity of the ear    \_\_\_\_ Pain/discomfort in ear    \_\_\_\_ Ringing or noises in the ear
- \_\_\_\_ Acute/chronic dizziness    \_\_\_\_ Drainage within the last 90 days    \_\_\_\_ Sudden hearing loss    \_\_\_\_ Diabetes
- \_\_\_\_ Unilateral loss in last 90 days    \_\_\_\_ High Blood Pressure    \_\_\_\_ Cerumen (ear wax) or any foreign body in ear
- Will this be your first hearing test? \_\_\_\_\_ Have you ever had ear surgery? \_\_\_\_\_

**May we send a report of your test to your Doctor if necessary? (circle one) Yes / No**

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**\*\*\*IMPORTANT! PLEASE READ CAREFULLY.\*\*\***

**All insurance must be presented *before* time of service if you would like us to file. You must present the front desk staff with your insurance card and driver's license at the time of *check-in* if you plan on filing insurance, otherwise we may choose to not accept it.**

Insurance Policy: In order to accommodate the needs and requests of our patients, we have tried to enroll in numerous managed care programs. While we are pleased to provide these services to you, it is impossible to keep up with all the individual requirements and stipulations regarding your policy.

**\*\*\*Our office policy requires payment at the time of service.\*\*\***

IT IS YOUR RESPONSIBILITY to provide correct insurance information and to understand your own insurance policy which may or may not cover all services and procedures. We will bill your insurance as a courtesy to you as our patient.

I understand the importance of having a complete audiological evaluation and authorize Audiology Associates of Georgia to bill my insurance carrier for the services rendered in my care. **I am fully aware that I am financially responsible for the balance of the bill regardless of insurance's coverage.**

I have read and understand the office policy stated above and agree to accept the responsibility as described above.

X \_\_\_\_\_

l Patient Signature \_\_\_\_\_